NEW QUALITY INFORMATION DEVELOPMENT

FINDINGS AND RECOMMENDATIONS

I. FINDINGS

The purpose of this paper is to identify ways in which the State can improve the quality-related information collected and available for consumers, providers, health plans, employers, policy makers and othersA well-informed and well-educated public with appropriate choice and access to quality health care is key to improved health. The current array of health care quality information is insufficient. Limitations include:

- Comparative data are scarce, and paper charts are not amenable to large-scale quality of care evaluations.
- Risk adjustment is needed to level the playing field for analyzing clinical outcomes, and to reduce adverse selection. (See the Task Force Paper on Minimizing Risk Avoidance Strategies.)
- Consumers, patients and purchasers do not have enough of the right sorts of information necessary to make informed decisions about health care options related to treatments, providers, plans[1], or carriers.

Providers are hampered in their ability to deliver excellent care by limited data to support evidence-based medicine. State efforts at data collection are limited by legislative micro-management, confinement to the hospital discharge abstract and long reporting cycles. These limitations impede the timeliness and usefulness of resulting information. To improve these shortcomings we recommend the following actions. Wherever possible, efforts should be coordinated among all levels of government and with the private sector.

There will be significant initial investment cost attached to expanding and enhancing the information about the quality of health care in California. The investment is necessary if we are to improve the quality of health care, managed or unmanaged. Moreover, by helping providers to learn which therapies work and which do not, improved data can contribute to reduced cost in the long run by eliminating ineffective or harmful therapies. Data should be collected and reported only if it can help providers improve the quality of care, reduce the cost of care (without reducing the quality of outcomes) and/or help consumers or purchasers choose among health plans and providers, or among treatment options.

[1] Plans, i.e., health insurance arrangements, also known as health benefits financial intermediaries.

II. RECOMMENDATIONS

A. Transition from a Statutory to a Regulatory Approach to Data Collection

1. (a) The Task Force recommends that the Legislature and the Governor give State health data programs the authority to request specific new data elements from health plans and providers to support new quality measurement initiatives. The Legislature and the Governor should set broad data guidelines, but give the State programs the flexibility to innovate.

   (b) The Legislature and Governor should authorize an advisory body composed of providers, health plans, purchasers, and consumers to evaluate specific data requests. Such requests should balance the cost and value of information to be provided. Redundant information requests should be reconciled. The advisory body should encourage data requesters to employ valid and reliable statistical sampling techniques when feasible.

B. Advance Implementation of Electronic Medical Records

Electronically storable and retrievable encounter and clinical data are needed so that medical groups and providers can monitor and improve their own practices, so health plans can monitor groups, so purchasers and accreditation organizations and the regulatory authority can monitor health plans and so purchasers and health plans can implement adequate risk adjustment mechanisms across health plans and providers.

2. (a) The Task Force recommends that the state's agency for regulating managed care be aware of, participate in, and actively help where possible, ongoing private and public sector efforts, such as those that have been initiated collectively by PBGH, NIPAC, AMGA, CMA and CAHP, to develop standardized eligibility, enrollment and encounter data.

   (b) The regulatory authority should require that components of electronic medical records (starting with encounter data), based on a system of open architecture (open architecture means systems that permit easy sharing and exchange of data) be phased in by component by 2002-2004 depending on the size and resources of the medical groups, health plans, clinics and hospitals.

   (c) This strategy should include strict provisions for maintaining patient privacy and confidentiality including fire walls between individual patient data and employers. The regulatory authority should impose severe penalties for individuals or organizations if they abuse the release of individual patient data. (See also the Task Force paper on Physician Patient Relationship)

   (d) The Task Force recommends to the President and the U.S. Congress that the federal government should assume responsibility for establishing technical standards for electronic communication of health care information (such as uniform identifiers for patients and providers and uniform language and data definitions), standards for

confidentiality and standards for information security. Federal initiatives in these areas will help ensure compatibility and comparability of information across states. This will assist the study of health outcomes regionally and nationally.

C. Collect Health Information at the Treatment Level

3. (a) The Task Force recommends that summary evaluative health care information (such as Risk Adjusted Medical Outcomes or RAMO) be collected and disseminated not only at the health plan level but at the treatment level including hospital, clinic, medical group/IPA, ambulatory center, home health and nursing home levels. Information should emphasize and compare outcomes whenever possible. (See the Task Force paper on Consumer Information, Communication and Involvement) Information should be reported by local geographic area where people are likely to seek and receive health care services.

   (b) The Task Force recommends that the health plan regulatory authority be aware of, participate in and actively help where possible, ongoing private sector efforts to develop and distribute these data and to take initiative only where no acceptable private sector efforts exist.

D. Study and Report Key Information Publicly

Comparative performance analysis is very important to consumers and purchasers choosing health plans and services. The public deserves the benefit of more in-depth study of the health services that they receive. In the long run, better care is likely to reduce costs.

4. The Task Force recommends that the Legislature and the Governor help identify both public and private funds for the State, or other public or private research entities as appropriate, to undertake a series of pilot studies. These research entities should involve appropriate stake-holders (including providers, representatives of vulnerable populations, plans and medical groups/IPAs and health policy experts) in designing and evaluating these pilot studies. In all cases, measurement methods may need to be developed or improved to ensure feasibility. Studies should seek to expand and enhance comparative performance analysis. The State should not duplicate existing research efforts currently underway in this area. Appropriate pilot studies may include the following:

   (a) Study and report by health plan:
   - Which health plans use available outcomes data to choose hospitals, medical groups, providers and other facilities for their network? What are the benefits to the public? Why do some plans use low volume hospitals for volume-sensitive procedures?

   (b) Study and report by health plan and medical group:
   - Who detects cancers at the earliest most treatable stages and achieves the best risk adjusted survival outcomes?
   - Who does the best job of changing patients' health behaviors such as smoking?

- Who does the best job of improving physiological scores such as lowering high blood pressure and high cholesterol?
- Who does the best job of improving functional outcomes for adults and children with chronic disease?
- Who does the best job of providing prenatal care, and achieving the best risk adjusted perinatal outcomes?
- Who does the best job of improving functional outcomes for individuals with depression or other mental health conditions?

(c) Study and report by hospital who does the best job with risk adjusted outcomes for certain procedures and conditions such as myocardial infarction (MI), major gastrointestinal surgery, coronary artery bypass graft (CABG) and autologous bone marrow transplant (ABMT)?

(d) Study all of the health plans and their associated hospitals and medical groups to determine who does the best job of involving patients in treatment decision making through education and respecting patient preferences.

Those pilot studies that prove valuable to the public, providers, purchasers or policy makers should be expanded state-wide, on an on-going basis.

E. Ensure Basic Safety Standards for Patient Care

There are some instances when quality information should be monitored to ensure the basic safety of the public. Collecting, monitoring, auditing and most of all improving clinical care based on these data serves a greater public good and should be required by public regulation and required by private accreditation.

5. (a) The Task Force recommends that the State's agency for regulating managed care create a blue ribbon panel (to include providers, health plans, consumers, purchasers and private accrediting organizations such as JCAHO and NCQA) to set maximum acceptable rates for adverse events and outcomes to ensure patient safety. Such events and outcomes might include:
   - infection rates and unplanned re-admission rates for inpatient and outpatient care
   - number and rate of adverse drug events for inpatient and outpatient care
   - risk adjusted mortality and morbidity rates for major surgeries and treatments

   (b) The Task Force recommends that this blue ribbon panel adjust these standards periodically to raise the bar of acceptable performance and enhance patient safety. Performance should be monitored and audited on a regular basis by the appropriate health plan and medical group regulatory authority, or delegated private accreditation body.

   (c) The Task Force recommends that if a medical group, hospital or other relevant health care organization cannot meet basic standards of patient safety in a specific area

of practice, then positive improvement action should be applied by the state's agency for regulating managed care or delegated private accreditation body. If improvement action fails to improve the practice deficiency within a specified time period, then patient activity in that specific area of practice should cease until acceptable performance and patient safety can be assured.